Performance

Report

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| Name of service: | Performance report date: |
| Rangeview Private Nursing Home | 28 September 2022 |
| Commission ID: | Activity type: |
| 3570 | Site audit |
| Approved provider: | Activity date: |
| Merakis Enterprises Pty Ltd | 12 July 2022 to 15 July 2022 |

This Performance Report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Rangeview Private (**the service**) has been considered by Alice Redden, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit, the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 26 August 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 1(3)(a): The provider ensures staff communicate with consumers and about consumers in a way that respects and maintains their dignity. The service ensures staff deliver care and services in a manner that protects consumer dignity. The service ensures consumer’s values are identified and used to inform care and services.
* Requirement 1(3)(d): The service ensures consumers who want to take risks are identified and supported to make informed decisions to accept those risks. The service ensures consumers are supported with appropriate strategies to minimise risk.
* Requirement 1(3)(f): The service ensures consumer personal information is handled in a way that protects confidentiality. The service ensures handovers occur in private locations within the service.
* Requirement 2(3)(a): The service ensures assessment and planning, including consideration of risks relating to falls, weight loss and pressure injuries, is used to inform care and services delivered.
* Requirement 2(3)(b): The service ensures assessment and planning identifies and addresses consumers’ current needs, goals and preferences, and consumers with end of life and advanced care plans are clearly identifiable in care plans.
* Requirement 2(3)(d): The service communicates outcomes of assessment and planning to consumers and documents them in care and services plans that are available to consumers and at the point of service delivery. The service will ensure information management systems are in place which support this outcome.
* Requirement 2(3)(e): The service ensures care and services are reviewed and care plans updated on a routine basis and when consumer needs or circumstances change or incidents occur.
* Requirement 3(3)(b): The service ensures high impact and high prevalence risks associated with the care of consumers, including in relation to falls, skin integrity, wound care and weight loss, are effectively managed.
* Requirement 3(3)(f): The service ensures referrals to relevant professionals are made in a timely manner.
* Requirement 3(3)(g): The service ensures infection-related risks are minimised by implementing standard and transmission-based precautions to prevent and control infection, ensuring there is a trained IPC lead on site and staff Personal Protective Equipment-use (PPE) and hand hygiene practices are monitored.
* Requirement 4(3)(f): The service ensures meals are served at the appropriate temperature.
* Requirement 5(3)(b): The service ensures consumers can move freely inside and outside the service, that way-finding aides are used, and equipment stored appropriately. The service ensures consumer rooms are cleaned to sufficient standard.
* Requirement 6(3)(c): The service ensures action is consistently taken in response to complaints and open disclosure practiced when things go wrong. The service ensures an effective complaints and feedback system is implemented.
* Requirement 6 (3)(d): The service ensures complaints and feedback are documented, opportunities for improvement identified and improvement actions implemented.
* Requirement 7(3)(a): The service ensures the number and mix of staff deployed enables the delivery and management of safe and quality care and services.
* Requirement 7(3)(d): The service ensures staff are supported to complete training linked to the Quality Standards.
* Requirement 7(3)(e): The service ensures staff performance appraisals are brought up to date and completed in line with service policy and procedure.
* Requirement 8(3)(a): The service ensures it engages consumers in the design, development, delivery and evaluation of care and services.
* Requirement 8(3)(b): The service ensures the governing body implements improvements specified in the Continuous Improvement Plan (CIP) provided to the Commission, to ensure it promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Requirement 8(3)(c): The service ensures deficits in organisational governance systems for information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints are rectified, and actions nominated in the CIP provided to the Commission are implemented.
* Requirement 8(3)(d): The service ensures there are effective systems in place for managing high impact, high prevalence risks, dignity of risk and incident management and prevention, as well as recognising and responding to abuse and neglect of consumers.
* Requirement 8(3)(e): The service ensures there is an effective Clinical Governance Framework in place which encompasses up-to-date and best practice policies relating to open disclosure, antimicrobial stewardship and the minimisation of restrictive practices. The service ensures staff receive education and training on these topics.

The Approved Provider implements all planned actions to address identified deficiencies and establishes monitoring process to ensure ongoing compliance with the Aged Care Quality Standards.

# Standard 1

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| Consumer dignity and choice | | Non-compliant |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Non-compliant |

## Findings

Following a site audit, the Assessment Team recommended Requirements 1(3)(a), 1(3)(d) and 1(3)(f) were not met.

Regarding Requirement 1(3)(a), the Assessment Team’s recommendation relied on observations and interviews with staff and consumers, which demonstrated some staff at times spoke about consumers in disrespectful ways or rushed consumer care in a way which deprived them of dignity. A named consumer said staff did not know their values and a representative considered staff tend to ‘ignore’ one consumer with a sensory impairment. Another representative considered staff engagement with a linguistically diverse consumer was ineffective. The Assessment Team found staff did not demonstrate familiarity with consumers’ backgrounds and did not personalise care as a result.

The Approved Provider’s response acknowledged some of the deficits outlined above and gave additional information to contextualise some evidence brought forth by the Assessment Team. The response included a Continuous Improvement Plan (CIP) and a Targeted Education Planner, which outlined improvement actions and staff education the Approved Provider plans to implement in response to the findings. The service has contracted an external consultant, to support them in responding to the site audit and has taken other steps, including a temporary pause on new admissions, to address the deficits. Relevant staff training to be delivered includes education on person-centred care, communication principles for people living with dementia and delivering culturally informed care.

While the service is taking appropriate steps to ensure consumers receive care and services that are respectful and protect their dignity, the steps taken after site audit do not demonstrate compliance. I have given weight to consumer and representative feedback, as well as the Assessment Team’s observations during the site audit. I am satisfied the service failed to ensure staff communicate with consumers and about consumers in a way that respects and maintains their dignity and that rushed care at times also detracted from consumer dignity. I also find the service did not ensure staff use knowledge of consumer values and identity to inform care and services. Therefore, I find Requirement 1(3)(a) non-compliant.

Regarding Requirement 1(3)(d), the Assessment Team found clinical staff were unaware of the service’s policy to complete risk assessments in consultation with relevant health professionals, for consumers opting to take risks. Management and staff were not able to identify any consumers being supported to take risks. Four sampled care plans did not contain risk assessments to identify risks and mitigation strategies for consumers who chose to disregard professional recommendations about bed poles and dietary modifications. Sampled care plans did not contain evidence of regular review by relevant health professionals, in light of the consumers’ risk-taking decisions. Sampled staff had not undertaken Dignity of Risk training, despite service policy requiring they do so.

In their response, the Approve Provider disagreed with some audit findings and accepted others. The response evidenced two consumers opting to ignore food texture recommendations had been reviewed by a speech pathologist and one of the consumers’ representatives had participated in a dignity of risk discussion where risks were identified and accepted. The response did acknowledge risks for one consumer had not been documented in their nutrition care plan and one consumer’s risk-taking was not reviewed as required. Regarding bed poles, the response acknowledged one consumer’s choice to use a bed pole contrary to professional advice had not been subject to a risk assessment, but disputed observations made by the Assessment Team a second consumer had a bed pole in place. The Approved Provider’s response also acknowledged areas for improvement and outlined several planned actions, including a review of all consumers to identify those who wish to take risks, updating risks assessment where necessary and an environmental review to ensure no other bed poles were in use.

Having regard to the site audit report and the response, on balance, I find there is sufficient evidence to support the non-compliant recommendation. I have placed weight on the direct observation evidence of the Assessment Team and am satisfied the service did not support two consumers to understand the risks of bed poles and did not implement appropriate safety strategies to mitigate those risks. Other consumers who were opting to ignore professional recommendations were not supported to do so in a safe manner, because their risk-taking was not documented in their nutrition care plan or had not been subject to routine review. As a result, I find the service did not properly monitor and manage the ongoing risk of choking for those consumers and did not support them to safely take risks. Although the response outlined steps taken since the audit to rectify these deficits, post-audit actions do not demonstrate compliance. Therefore, I find the service is non-compliant with Requirement 1(3)(d).

Regarding Requirement 1(3)(f), the Assessment Team found the service did not take steps to keep personal information of consumers confidential. During the Site Audit, the Assessment Team witnessed a handover taking place at a nurse’s station that has no door, within earshot of passers-by. The Team also observed an unlocked nurse’s station with sensitive consumer information left visible on the desk inside. Other evidence put forth by the Assessment Team was either irrelevant or was refuted by the Approved Provider’s response, and as a result, has not been considered.

In their response, the Approved Provider disagreed with the Assessment Team’s findings and argued prior to the site audit, staff had been instructed to hold handovers elsewhere. While I accept this instruction was given, the Assessment Team’s observation showed it was not followed. Other arguments put forth in the response were not supported by evidence and did not overcome the Assessment Team’s direct observations of sensitive personal information being left on desks. As a result, I find the service did not take practical steps to ensure consumers’ confidential information is protected from unauthorised access or accidental disclosure to others in the service environment. Therefore, I find the service is non-compliant with Requirement 1(3)(f).

Regarding the remaining requirements, consumers said the service meets their cultural needs and supports them to engage in meaningful activities important to their identity. Staff explained how they support consumers from culturally and linguistically diverse backgrounds. Organisational policies and procedures were in place to identify and address consumer cultural needs and requirements.

Consumers said they are supported to maintain personal relationships. Staff knew sampled consumers’ important relationships and outlined ways they are guided by consumer preferences in care and services delivery. Care plans reflected consumers’ preferences and needs in relation to lifestyle, social and emotional needs.

Consumers and representatives said the service generally provides timely and accurate information that supports consumers to exercise choice. Staff described how they support consumers with communication barriers to understand information provided. Menus, activity calendars and other notices were displayed throughout the service and information was observed being provided directly to consumers.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

## Findings

The Assessment Team recommended Requirements 2(3)(a), 2(3)(b), 2(3)(d) and 2(3)(e) were not met.

Regarding Requirement 2(3)(a), the Assessment Team identified three consumers did not have updated skin risk assessments or care plans after developing pressure injuries. The consumers’ care plans did not mention the pressure injuries and lacked strategies to assist healing of injuries. The team also identified deficits in assessment and planning relating to weight loss, where swallowing assessments and dietician referrals were not conducted following weight loss for five consumers, contrary to service policy, and nutritional assessments were also not completed. Care plan review showed the service is not consistently reviewing risk to inform falls prevention strategies, with four consumer care plans showing Falls Risk Assessment Tools (FRATs) were not completed following unwitnessed falls. The Assessment Team also relied on evidence the service did not have appropriate risk assessments for bed poles, as outlined in Requirement 1(3)(d). Finally, interviewed registered staff could not demonstrate shared understanding of service policy and procedures relating to care plan review, risk assessment and management of consumers with weight loss or swallowing difficulties.

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation and argued against some of the findings. In relation to skin and wound care assessment and planning deficits, the response acknowledged appropriate risk assessments had not been completed and care plans updated in response to pressure injuries in the three named consumers but demonstrated that wound care charting and wound management directives were in place for some. In relation to weight management, the response argued the weight loss of named consumers had been taken out of context, however it did not provide any evidence to show the service procedure had been followed. The response contained nutrition assessments completed after the site audit for the named consumers. Regarding bed pole use, the service’s response has already been outlined in Requirement 1(3)(d). Regarding post falls management, the service response acknowledged FRATs were not consistently completed following unwitnessed falls and provided evidence these had since been completed. The response did not refute evidence from staff interviews.

Having regard to the site audit findings and the response, I am satisfied the service is not compliant with Requirement 2 (3)(a). Evidence showed a pattern of staff not completing risk assessments in response to changes in condition or incidents which signalled increased risk to consumers. Unwitnessed falls did not result in reassessment of falls risk in a timely manner, so updated falls prevention strategies could be implemented in practice. Skin risk assessments were not actioned so new care strategies could be identified and implemented and weight loss in several consumers did not consistently result in supplements being initiated or onward referrals being made, as per service policy and procedure. Therefore, I find the service did not ensure assessment and planning, including consideration of risks to consumers health and well-being, informed care and service delivery. Therefore, I find the service is not compliant with Requirement 2(3)(a).

Regarding Requirement 2(3)(b), the Assessment Team found consumer care plans did not accurately reflect consumers’ current needs, goals and preferences, including in relation to advance care planning. They found the service relied on clinical handover sheets to record current care needs but a sample handover sheet reviewed by the Assessment Team contained inaccurate information. Care plans for two sampled consumers were not updated to reflect current needs contained on handover sheets. The Assessment Team also found that while the service had conducted advanced care planning and end of life planning with consumers, these were stored in physical files and care plans did not say which consumers had completed end of life plans or ACPs. Staff interview evidence demonstrated staff rely on handover sheets rather than care plans and that the service was behind in care plan reviews, which was confirmed through documentation review.

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation but also acknowledged current care needs for the two named consumers were not recorded in care plans. The response outlined steps taken since the audit to rectify those deficits but did not address findings for a third consumer. The response argued handover sheets documented those consumers with advanced care or end of life plans on file, but it did not address staff interview and care plan evidence put forth in the site audit report for Requirement 2(3)(b).

Having regard to the site audit findings and the response, I find the service is non-compliant with Requirement 2(3)(b). I have taken into account my finding in Requirement 2(3)(a), the appropriate assessments were not used to inform care plans and as a result, these did not accurately convey all consumer needs in relation to falls, weight loss and pressure injury risks. I accept care plans were not up to date and accurate, and while they were not the primary source of information, the handover sheets which staff relied upon were not comprehensive or consistently accurate. I accept end of life and advanced care planning occurred, however care plans did not document who had those plans in place or where to find them. Although handover sheets may have contained this information, evidence of this was not provided to the Commission. This raises concern new or relief staff would not have knowledge or access to information on consumers end of life wishes or advanced care directives. For the reasons outlined above, I am satisfied that the service did not ensure assessment and planning identified and addressed current needs goals and preference, or those relating to advanced care planning and end of life care. Therefore, I find the service is not compliant with Requirement 2(3)(b).

Regarding Requirement 2(3)(d), the Assessment Team found the service did not effectively communicate outcomes of assessment and planning to consumers or document them in care and service plans that are available to consumers and at the point of service delivery. They relied on care plan evidence which showed a consumer’s current pressure injury had not resulted in updates to their skin assessment and care plan and a second consumer’s recent weight loss and high energy high protein dietary requirements were not reflected in their nutrition and hydration care plan. Other evidence showed the service had switched from electronic to paper-based care plans, which though available for visiting professionals to review, were not always updated following changes in consumer condition or need. Consumer and staff interview evidence showed care plans are not consistently offered to consumers and representatives and there is no system in place to ensure this occurs. Allied Health Professional interview evidence demonstrated the outcomes of review are documented in a progress notes but does not result in updates to mobility care plans. A clinical staff member said manual clinical care system was used inconsistently and gave an example of being unable to find the information about when a consumer’s catheter required changing and clinical monitoring at the service was deficient and had not identified the issues. Other evidence put forth by the Assessment Team in this Requirement was relevant to review of care plans and is considered in relation to Requirement 2(3)(e).

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation, without leading evidence to refute findings they disagreed with. The response also acknowledged care plans did not contain up to date information about one consumer’s current pressure injury and another consumer’s weight loss and dietary requirements, but emphasised the information was recorded in other locations. The response outlined steps taken since the audit to update those identified documentation deficits. The Approved Provider also acknowledged the findings and evidence which showed care plans are not routinely offered to consumers and representatives.

Having regard to the findings and the Approved Provider’s response, I find the service failed to effectively communicate the outcomes of assessment and planning in care plans that were readily available to consumers and others at the point of service delivery. Accurate and current care and services plans are important for delivering safe and effective care and services and where plans are missing information or contain contradictory information, consumer safety may be compromised. Consequently, I have placed weight on evidence from staff and an allied health professional that paper-based care plans were not kept current with assessed consumer needs, particularly since the service transitioned away from an ECMS. I also gave weight to consumer and staff interview evidence that care plans are not offered to consumers and representatives. As a result, I am satisfied the outcomes of assessment and planning were not clearly and consistently communicated in care plans to be available at the point of service delivery and care plans were not consistently provided to consumers. Therefore, I find the service is non-compliant with Requirement 2 (3)(d).

The Assessment Team recommended Requirement 2(3)(e) not met because they identified care plans were not updated every three months, as per service policy, or when consumer needs and circumstances changed or when incidents occurred. The Assessment Team cited evidence five consumer’s care plans had not been updated, or incident reports completed, in response to those consumers’ falls, pressure injuries and skin tears. One of those consumer’s falls had not resulted in an updated FRAT. Staff interview evidence showed incident reports were not always actioned due to staff shortages and that incidents had been efficiently tracked when the ECMS was used but had become difficult to track with the shift to a paper-based incident system since a change in ownership of the service.

The Approved Provider’s response did not agree with all findings but acknowledged deficits in care planning and the need for improvement in incident reporting. The response did not directly acknowledge staff interview evidence, or evidence care plans are not reviewed as per service policy and procedure, however the CIP provided with the response showed the service has plans to reinstate the ECMS and planned staff education in its use. Other planned improvements include the implementation of an electronic incident management system, review of the organisation’s clinical governance systems and review of all policies and procedures related to assessment and planning, staff education and a review and reassessment of all consumers in relation to high impact, high prevalence risk areas.

Having regard to the audit findings and the response, I am satisfied the service did not ensure care and services were reviewed when needed or care and services plans were an accurate and current reflection of consumer’s needs, goals and preferences. I am satisfied sampled care plans did not communicate important information relating to consumer risks in the areas of falls prevention, wound care and skin integrity and I find care and services were not consistently reviewed in response to incidents, because of deficits in incident reporting. I have also considered other findings, medications classified as chemical restrictive practices were not regularly reviewed by a medical officer or a nurse practitioner. While I acknowledge the service’s improvement plan, and steps already taken to address the deficits, as they are taken after the site audit, they do not demonstrate compliance. Therefore, I am satisfied the service is not compliant with Requirement 2(3)(e).

Regarding the remaining requirement, care planning documentation demonstrated consumers and representatives are included in assessment and planning processes, alongside professionals including medical officers, allied health professionals and others. Most consumers and representatives confirmed they were included in ongoing and assessment and planning. Staff said consumers and representatives are consulted through resident of the day processes, when there are changes and when medical review is required.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

## Findings

The Assessment Team recommended Requirements 3(3)(a),3(3)(b),3(3)(f) and 3(3)(g) were not met.

Regarding Requirement 3(3)(a), the Assessment Team recommended not met on the basis of evidence previously outlined and considered in Standard 2. Evidence put forth related to deficits in assessment and planning, as well as considerable deficits in understanding of chemical and environmental restrictive practices. The Assessment Team lead evidence the service had systemic deficits in compliance with restrictive practices legislation, however no evidence was provided to demonstrate those deficits in documentation, assessment and planning resulted in identifiable impact to consumers. As a result, evidence of poor compliance with restrictive practices legislation has been considered in relation to regulatory compliance governance, in Requirement 8(3)(c). The site audit report contained minimal evidence concerning the actual delivery of personal and clinical care which resulted in identified impact to consumers in Requirement 3(3)(a). Poor representative feedback concerning one named consumer who had identifiably ineffective care was provided, but alone was insufficient to support the Assessment Team’s recommendation. The evidence was relevant to Requirement 3(3)(b) and has been considered there instead.

Remaining evidence in Requirement 3(3)(a) showed the service’s management of pain to be effective, wounds were generally monitored, wound care directives were in place and generally adhered to, handover sheets contained sufficient information to support delivery of care and the service made use of a nurse practitioner and a resident in-reach service. The remaining evidence put forth by the Assessment Team was either relevant to non-compliant findings in Requirements 8(3)(c) and 7(3)(a), or it supported compliance. As a result, I have reached a different conclusion than the Assessment Team, and find the service is compliant with Requirement 3(3)(a).

Regarding Requirement 3(3)(b), the Assessment Team recommended not met as sampled care plans did not consistently identify current risks or management strategies and falls and skin risk assessments were not consistently completed when they should have been, as outlined previously. The Assessment Team found four consumer’s weight loss had not been managed in accordance with service policy, swallowing assessments were not conducted, referrals to dieticians had not been made and/or high energy high protein supplements had not been commenced. FRATs had not been completed following unwitnessed falls for four consumers, contrary to service procedure. Additionally, care plans did not reflect the falls or falls prevention strategies and incident forms were not consistently completed. New skin care risk assessments had not been completed for five consumers after changes in their skin condition and care plans did not contain strategies to promote healing, though it was noted that wounds were attended to and monitored. One consumer was observed with a wound that was being attended to but did not have a wound chart in place.

The Assessment Team also found a representative voiced concern their relative had chronic wounds which they believed were not adequately cared for. Another representative was concerned staff did not have enough time to provide supplements to their relative who had lost weight, while a consumer who had sustained weight loss since their admission said they had not seen a dietician. Management interviews during the site audit acknowledged deficits in documentation for skin, weight loss and falls, as well as the missing wound chart for one named consumer, and noted the difficulty in updating care plans when incidents occur.

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation but acknowledged the care planning and risk assessment deficits, as previously outlined in Standard 2. The response emphasised positive consumer feedback and other audit findings that suggested compliance with the Requirement and also included information about the named consumer whose representative was concerned they did not receive adequate care for their chronic wounds. While the evidence showed the wounds were being attended to, it did not conclusively demonstrate an adequate level of care provided during a period when the wound deteriorated. The response also outlined the comprehensive steps being taken to address deficits since the site audit, some of which have been outlined previously in Standard 2. The CIP also listed (but was not limited to), undertakings to: review consumer care plans to ensure all risks are identified and safety strategies documented, provide staff education on risk assessment, care planning and mitigation strategies, strengthen referral pathways to dieticians, speech pathologists and physiotherapists and introduce daily clinical incident reviews and reporting. The Approved Provider also assured an immediate review of care plans and risks for consumers named in the site audit report had been commenced.

I acknowledge the service is taking considerable steps to address the deficits identified by the Assessment Team. However, at the time of the site audit, the service was not effectively managing the high impact and high prevalence risks associated with the care of consumers, in relation to falls, skin integrity, wound care and weight loss. The service had not identified or effectively monitored consumers with known risks to ensure the risks were being managed effectively and management strategies for falls and skin care were not documented in consumer care plans, which differed from the handover sheets relied on by staff in the delivery of care. The service’s own policy and procedures for weight loss and falls were not consistently adhered to and while there was not conclusive evidence of detrimental impact to consumers, the deficits in risk assessment for falls and skin were systemic in nature. While I acknowledge the service has relevant policies and procedures in place to guide staff in their management of high impact, high prevalence risks, evidence demonstrated staff adherence to policies and procedures is not embedded. A switch from an ECMS to a paper-based care plan system appears to have undermined ability of the service to appropriately manage risks. For the reasons outlined above, I find the service is non-compliant with Requirement 3(3)(b).

Regarding Requirement 3(3)(f), the Assessment Team recommended not met, as some consumers who had experienced falls were not reviewed in a timely manner by a physiotherapist, as required by the service’s own policy and procedure and physiotherapists also did not review bed pole risks, as previously outlined. The Assessment Team also relied on evidence previously outlined, several consumers who had lost weight were not referred to a dietician, as required. Staff and management interview evidence also demonstrated there was no dietician in regular attendance at the service, no regular podiatry service, there had been difficulty in getting regular medical officer attendance and that since the service ceased use of its ECMS, automatic referrals to physiotherapists after a fall no longer occurred. A consumer was concerned about waiting to see a podiatrist. Other evidence was not relevant and has not been considered.

The Approved Provider’s response demonstrated some, but not all consumers who had experienced falls were reviewed in a timely manner by a Nurse Practitioner or the physiotherapist. The response disagreed with Assessment Team findings about the consumers who had experienced weight loss, but the response did not demonstrate that the service’s own policy to refer consumers to a dietitian had been followed. The response did not address the issue of podiatrist referrals and it included evidence staff had been given contact details for after hours medical officers.

Having regard to the site audit findings, the Approved Provider’s response and supporting evidence, I find that while the service did at times ensure consumers who fell were reviewed by a nurse practitioner or physiotherapist, this did not consistently occur and as a result, the service’s own policy was not always complied with. Similarly, the service’s own policy for referral to a dietician was not followed by the service, in relation to the any of the sampled consumers. I also find one consumer had not been referred on to a podiatrist in a timely manner. While the Approved Provider response details steps being taken to strengthen referral pathways to various allied health professionals are now being taken, I find that at the time of site audit, the service did not ensure they had an active network of providers, organisations and individuals they collaborated with, to meet consumers’ diverse needs. Where there were referral pathways in place, referrals were either not made at all, or not consistently made in a timely manner. For the reasons outlined above, I find the service non-compliant with Requirement 3(3)(f).

Regarding Requirement 3(3)(g), the Assessment Team recommended not met as, although the service has a documented infection and outbreak management plan for COVID-19 in line with national guidelines, observation of staff practices identified preventative strategies were not consistently followed as several staff in various parts of the service were observed not wearing masks or wearing them incorrectly, hand hygiene practices were not followed and hand sanitiser stations were left empty over days. The Assessment Team also found requirements for the on-site Infection Prevention and Control (IPC) Lead were not met, as the nominated lead had not completed required training and did not understand the role and its responsibilities. An interviewed representative said they have never had to undertake a Rapid Antigen Test when visiting the site, despite this being a screening requirement for entry to the service. The Team also found there was no cleaning schedule in place for shared equipment and some staff said at times the shared equipment may not be sufficiently cleaned between users. Other evidence brought forward was refuted by the Approved Provider’s response and has not been outlined here.

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation and argued the nominated IPC lead had been enrolled in relevant training at the time of site audit but provided no evidence to support this. The response acknowledged the Assessment Team’s observations of poor staff hand hygiene and PPE-use during the site audit and provided evidence to show remedial action had been taken and refresher training on standard precautions, PPE use and hand hygiene is planned to rectify the deficiencies in staff practice. The response emphasised there is not a high rate of infection at the service and impacts and exposure to COVID 19 had been limited at the service.

Having had regard to the site audit findings and the Approved Provider’s response, I find the service is not compliant with Requirement 3(3)(g). While there is no evidence of high infection rates at the service, observations showed generally poor adherence to PPE requirements and hand hygiene, in particular and a lack of a suitably trained IPC lead to monitor this. While acknowledging the lack of evidence to show high rates of infection and/or transmission of infection in the service, the observations during site audit showed the service was not effectively minimising infection-related risks by implementing standard and transmission-based precautions to prevent and control infection. For this reason, I find the service is non-compliant with Requirement 3(3)(g).

Regarding the remaining requirements, the service maintains advanced care and end of life plans for consumers who have chosen to complete them. Representatives confirmed they had participated in end of life and advanced care planning. Staff demonstrated understanding of how care changes when a consumer nears end of life. The service has access to end of life care support from the local hospital.

Care planning documentation demonstrated the service identifies and responds to deterioration and changes in condition. Consumers and representatives confirmed the service is responsive to changes in consumer pain, and blood glucose levels, for example. Staff outlined how they had responded to recent changes and deteriorations in consumer behaviour and physical health.

Although consumer care plans were not consistently updated, the service communicates some information about consumer condition, needs and preferences in clinical handover sheets, progress notes and verbal handover processes.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

## Findings

The Assessment Team recommended Requirement 4(3)(f) was not met because although meals were varied, the majority of consumers interviewed said meals are frequently served cold. Staff interviews indicated this issue had been addressed through the purchase of a bain-marie, but only in one wing.

The Approved Provider’s response indicated the service had not received complaints regarding the temperature of meals prior to the site audit. They confirmed a bain-marie had been purchased for one wing and indicated the other wing has a meal servery directly inside the wing. The response stated they received different feedback from consumers after the site audit but did not provide evidence of this to support their arguments. The response did include evidence the service has temperature monitoring processes in place, however did not demonstrate the temperature monitoring logs had been used prior to the site audit. Overall, on balance, evidence provided to demonstrate compliance did not outweigh the clearly negative consumer feedback regarding meal temperature. Although the response disagreed with the Assessment Team recommendation, the CIP provided indicted a second bain-marie has been purchased and temperature monitoring is being completed, in response to audit findings.

I acknowledge the service is taking appropriate steps to respond to consumer feedback about cold meals. I also acknowledge the remaining site audit evidence that showed meals provided are of suitable variety and standard. However, I have placed considerable weight on consumer feedback to find at the time of site audit, meals were not consistently being provided at an appropriate temperature. Meals and dining experiences are a very significant part of daily life and meals which are not enjoyable contribute to consumer health and well-being, as they may contribute to weight-loss. Having regard to the evidence and the response, on balance I find the service failed to ensure consumers meals where of suitable quality, because they were frequently served cold. Therefore, I find the service is non-compliant with Requirement 4(3)(f).

Regarding the remaining requirements, consumers said they were happy living at the service and they receive the lifestyle and daily living support they need and want. Care plans document consumers’ favourite activities. Staff knew what is important to sampled consumers and how they like to spend their time.

Consumers confirmed staff provide them with emotional support when needed and they are encouraged to engage in activities that help them feel good. Staff and a volunteer outlined ways they respond to consumers who are feeling low or ‘need a chat.’ The Assessment Team observed staff encouraging and reassuming consumers during the site audit.

Consumers said they are supported to keep in touch with family and friends, as well as to participate in interesting activities at the service, however some reported missing regular bus trips, which were suspended while the service acquired a new bus. Care plans documented important relationships for sampled consumers. Consumers were observed participating in a range of activities during the audit and volunteers were also observed interacting with consumers. Staff described regular activities in the service, including concerts, happy hours and a snack bar.

Consumers and representatives considered staff know their needs, preferences and routines. While care plans were not consistently updated, information about consumer conditions, needs and preferences related to lifestyle is adequately communicated to those involved in care.

Consumers confirmed they have access to allied health and lifestyle supports they need when they need them, including religious visitors. Staff described the organisations and services used to supplement the service’s lifestyle program, which includes a volunteer program that runs lifestyle initiatives on site, such a café, concerts and happy hours.

Equipment used to support consumer daily living and lifestyle needs was safe, well-maintained and fit for purpose. Consumers said they were happy with the equipment used in their care and maintenance issues are promptly attended to. Staff confirmed access to the equipment they need and outlined the preventative and reactive maintenance programs in place at the service. Review of maintenance logs confirmed issues are reported and actioned in a timely manner.

# Standard 5

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| Organisation’s service environment | | Non-compliant |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

## Findings

The Assessment Team recommended Requirement 5(3)(b) not met as consumers were not able to move freely inside and outside the service because consumers did not have access to the keycode for locked doors. Environmental restrictive practices in place were not recognised, were not used in compliance with legal requirements and three consumer/ representative interviewees said consumers could not freely exit the service as they would like, because they did not have access to the front door code. The Assessment Team also observed a lack of wayfinding aides to support consumers with cognitive impairment and observed one consumer with a cognitive impairment having difficulty finding their way. Handrails in internal hallways were observed to be obstructed by consumer mobility equipment, kitchen trolleys and wheelchairs. One consumer representative raised concerns about the standard of cleaning in consumer rooms. Some equipment was observed to be in poor condition and a tripping hazard was observed in an outdoor area. Other evidence put forth in the site audit report was refuted by the response and has not been considered here.

In their response, the Approved Provider disagreed with other Assessment Team recommendations, however their response could not refute the direct observations of the Assessment Team during the site audit. The response did acknowledge deficits in the management of environmental restrictive practice, which confirms restraints have been placed on consumer freedom of movement, without legal requirements being met, but clarified that consumers can access an outdoor patio area freely. The response acknowledged deficits in wayfinding for consumers, however the response did not confirm how the service environment would be modified to address the lack of navigational aids. The targeted education plan confirmed staff would receive training in restrictive practices. Other evidence put forth by the Assessment Team was not addressed or acknowledged in the response.

Having had regard to the site audit findings and the Approved Provider’s response, I am satisfied the service was not providing a safe and well maintained service environment that enabled consumers freedom of movement. I have placed considerable weight on the Assessment Team’s direct observations, particularly in relation to obstructed handrails and walkways and lack of navigational aids in the service environment. I am satisfied at least three consumers’ desire and right to freely exit the service has been constrained without the necessary legal requirements being met and the service environment itself does not enable consumers to move about freely because of lacking navigational aids, obstructed walkways and obstructed rails. I also note some concerns around cleaning of consumer rooms, which has informed this finding. For the reasons outlined above, I find the service is non-compliant with Requirement 5(3)(b).

Regarding the remaining requirements, observations confirmed the service to have wide corridors, communal areas for socialising and consumer rooms spread across a single level, supporting consumer independence and mobility. Consumer rooms are personalised and quiet communal spaces with seating are distributed throughout the service. Consumers said they feel at home in the service and particularly enjoy the natural light.

The service generally had equipment, furniture and fittings which are safe, clean, maintained and suitable for use. Consumers who need mobility aids were observed using them to move about the service. Consumers and representatives were generally satisfied with furniture, fittings and equipment at the service. Corrective maintenance logs indicated maintenance issues are rectified.

## Standard 6

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| Feedback and complaints | | Non-compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

## Findings

The Assessment Team recommended Requirements 6(3)(c) and 6(3)(d) were not met.

Regarding Requirement 6(3)(c), the Assessment Team found the service did not consistently take action in response to complaints or practice open disclosure when things go wrong. The not met recommendation was based on mixed consumer interview evidence, with four interviewees stating complaints either did not result in action or action was not timely or required repeated follow up from complainants. Although the service has an open disclosure policy and procedure, interviewed staff said they had not received, or could not recall receiving, open disclosure training and could not demonstrated shared understanding of its’ principles or application. Interviews with staff also showed meeting minutes from consumer and representative meetings were not consistently shared with management to ensure complaints and feedback raised are actioned. Three feedback forms mentioned by interviewed consumers were not located in the complaints and feedback folder. The service complaints and feedback folder contained only three complaints and for those, the register did not consistently document follow up actions, open disclosure processes, response to complainants or actions taken to support closure, though two had been closed. A third was many months old and did not reflect follow-up actions, response to the complainant or open disclosure. Finally, the Assessment Team found verbal complaints were not being documented and actioned and trending of complaints and feedback did not occur.

In their response, the Approved Provider acknowledged the deficits identified and outlined steps taken, and planned, to rectify the deficits, including (but not limited to) review and closure of all outstanding feedback items, a total review of the organisation’s complaints system and policies, introduction of more frequent monitoring of complaints, review of the complaints investigation process and staff training on open disclosure and feedback processes.

I acknowledge the service is taking steps to improve the handling of complaints and feedback to ensure consumer concerns are resolved, however at the time of site audit, the service did not have effective and functioning complaints and feedback handling processes in place. Complaints were not consistently documented, follow up actioned and open disclosure principles applied. Services are expected to acknowledge when things have gone wrong and to encourage and support people to identify and report negative events. Based on the evidence put forth, I am satisfied the service did not consistently meet these expectations. Therefore, I find the service is not compliant with Requirement 6(3)(c).

Regarding Requirement 6 (3)(d), the Assessment Team found the service does not review feedback and complaints to make improvements at the service. They relied on evidence already outlined above and consumer and representative interview evidence that consumer complaints about cold food had resulted in the purchase of one bain-marie, but its’ use was inconsistent, and meals were still being served cold. Management said the continuous improvement register had not been updated in almost a year and that, although the owner of the service attends the service and has direct conversations with consumers to seek feedback, the service could not demonstrate any complaints and feedback received by the owner were documented in the complaints register, trended or used to inform improvements. Document review confirmed the continuous improvement register had not been updated in almost a year and did not include complaints from the complaints register and how they were used to drive improvements at the service.

In their response, the Approved Provider acknowledged the deficits identified at audit and outlined several actions already taken or planned to improve the service’s performance. Planned actions include implementing a “You said, we did” communication board to publicly demonstrate to consumers, representatives and staff how feedback is being used to improve care and services, adapting the consumer newsletter and meeting format to report on complaints received and actions being taken in response and introducing reporting to Directors on complaints and feedback handling.

While I acknowledge the Approved Provider’s response and the suitable actions they have planned to address the deficits identified, actions taken after audit do not demonstrate compliance. The evidence brought forth by the Assessment Team showed that complaints made by consumers in the past have not been systematically documented, trends identified and opportunities for improvement taken up. Quality improvement systems in relation to food temperature were shown to be ineffective, and evidence of other service level improvements were not identified. I am satisfied that the service also did not regularly review and improve how they manage complaints. Consequently, I am satisfied the service is not compliant with Requirement 6(3)(d).

Regarding the remaining Requirements, most consumers and representatives said they are generally encouraged to provide feedback and raise concerns and felt safe to do so. Consumers and representatives understood how to raise concerns and provide feedback either verbally or through feedback forms. Staff described processes followed when supporting consumers to make a suggestion or complaint.

Some consumers and representatives said they were aware of external advocacy and complaints services and others said they felt more comfortable to approach staff and management directly. While interviewed staff knew how to support consumers in making complaints, they described relying on the representatives of Non-English-speaking consumers, rather than using accredited interpreters. Information about external complaints avenues and advocacy services were displayed throughout the service.

**Standard 7**

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| Human resources | | Non-compliant |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

## Findings

The Assessment Team recommended requirements 7(3)(a), 7(3)(d) and 7(3)(e) as not met.

Regarding Requirement 7(3)(a), the Assessment Team recommended not met due to consumer and representative evidence the service is short-staffed, with impact to consumers as a result. Eight interviewees gave evidence of rushed or delayed personal care. Three interviewees said responses to call bells can be slow and three raised concerns staff did not have time to support consumers with their supplements and meals. Two consumers raised concerns personal care, including removal of stockings and stoma management, had not been attended to in evenings while others said staff no longer had the time to talk. Interviewed care workers reported high turnover of staff and said training new staff took time, that consumers were upset by constant new staff and there were high rates of unplanned leave leading to unfilled shifts. Registered staff reported there had been a substantial number of resignations with some key personnel resigning, no current site manager and the clinical coordinator covering registered staff duties at times. Registered staff said they were frequently diverted from clinical tasks to orient new staff. Interviews with management indicated although there is a planned approach to rostering, due to the number of resignations, there are currently not many consistent staff, with vacant shifts filled by casuals and recruitment underway at the time of site audit. Finally, the Assessment Team found the service does not audit call bell and sensor mat response times, as the system does not produce reports.

The Approved Provider’s response clarified some evidence brought forth by the Assessment Team, noting that the resignations had occurred since April 2021 when ownership of the service changed hands, and argued the resignations were natural attrition in response to significant workplace change. The response argued the service had taken significant steps to upskill the workforce, increase the number of registered staff and recruit more staff. The response noted that 35 care staff had been recruited since the service was acquired with only one resignation reported. The Approved Provider disagreed with staff evidence that training of personnel diverts them from their roles, however the response did not contain evidence to support their arguments. Further context and information were provided to clarify some evidence in the site audit report, which also referred to the current workforce shortages in the industry. The response argued staff numbers had increased overall since the change in ownership, RNs are now onsite across all shifts, a nurse practitioner engaged, and key personnel positions filled, however no evidence was provided to support these statements. The response acknowledged the deficits in the call bell system, demonstrated that investigations for a replacement system had commenced some time prior to the site audit and the system had been replaced in one part of the service prior to audit. The response included an undertaking to commence monthly call bell audits once the new system had been installed and it acknowledged consumer feedback staff are rushed but contested or clarified other representative feedback.

Having regard to the site audit report, and the Approved Provider’s response, I find on balance, there is sufficient evidence to support the Assessment Team’s not met recommendation. While the Approved Provider’s response refuted some evidence of non-compliance, on balance, it did not overcome the consistently negative consumer and representative evidence brought forth in the audit report. In addition, while I accept the service had identified the deficient call bell system some time prior to site audit, the deficits were not rectified by the time of audit, and consumers continued to experience slow call bell response times. I have also had regard to the deficits in assessment and planning outlined in Standard 2 and deficits in risk assessments, in Standard 3. I find these deficits, attributed to shortfalls in staff, extra work created by the shift away from an ECMS and the diversion of staff away from their primary duties to train new staff or to fill other roles, indicates non-compliance in this Requirement. While I acknowledge the service has a planned approach to rostering and recruitment, I find the number of personnel and mix of personnel deployed has not enabled the consistent delivery of quality care and service. Therefore, I find the service is not compliant with Requirement 7(3)(a).

Regarding Requirement 7(3)(d), some evidence relied on by the Assessment Team to support their not met recommendation was not relevant to the Requirement or was evidence that was more relevant to other Requirements. Remaining relevant evidence included interview evidence from care staff who said the service had not asked them if they required any additional training, and feedback that while there is mandatory online training, the additional training offerings were limited in scope. Management did not explain how additional training needs, beyond mandatory training is identified. Review of documentation showed that most sampled staff had not completed required mandatory modules. Training in relation to the Serious Incident Reporting Scheme (SIRS) and restrictive practices had also not been completed by staff. Other evidence cited by the Assessment Team has been outlined and considered in relation to other Requirements, and centred on gaps in training that had corresponding, identified deficits in practice.

In their response, the Approved Provider disagreed with the not met recommendation and gave an overview of the training and recruitment processes in place to ensure staff are qualified to perform in their roles. The response acknowledged opportunities for improvement in staff training and the targeted training planner provided with the response demonstrated the Approved Provider’s plan to improve training in all areas linked with all Quality Standards. While the response noted staff were in the process of completing mandatory training requirements, no evidence was provided to disprove the audit finding staff mandatory training was overdue for a significant number of staff at the time of site audit.

I acknowledge the service has a comprehensive education and training plan in place to support staff development and to address the deficits identified by the Assessment Team. However, steps taken after site audit do not demonstrate compliance. At the time of site audit, I am satisfied staff were overdue to complete mandatory training in areas where actual deficits in staff practice were also identified at site audit and staff had not been supported to access training needed to perform their duties and deliver the outcomes required by these Standards. Deficits in restrictive practices training completion were identified and deficits in the actual management of restrictive practices were found. Staff had not completed training in open disclosure, and as outlined in Standard 6, clear deficits in understanding and application of open disclosure were identified in practice. I have also given weight to staff and management interview evidence which indicates there is no process in place to identify additional training needs. For these reasons, I find the service is non-compliant with Requirement 7(3)(d).

Regarding Requirement 7(3)(e), the Assessment Team recommended not met because although the service has policies and procedures for staff performance monitoring, review and management, all interviewed staff said they had not had a performance review or appraisal in over one and a half years, since the change in ownership of the service. New staff were not aware of performance review processes. While the clinical care coordinator reported the service had engaged a nurse practitioner to support with clinical staff training and oversight, they could not specify any formal or informal staff performance assessments the nurse practitioner had been involved in. Performance appraisal records could not be provided, and management acknowledged that appraisals had not been completed since April 2021. Other evidence put forth by the Assessment Team was not relevant and has not been considered here.

In their response to the site audit report, the Approved Provider disagreed with the not met recommendation however conceded that staff performance appraisals were overdue. The response assured the service has a plan to bring appraisals up to date and noted there were performance appraisal tools in place. The response argued the service had been monitoring staff performance and supporting staff in other ways, as well as identifying and responding to staff performance issues. However, the response did not include any evidence of this occurring in practice.

While I am satisfied the service has a plan to bring staff performance reviews up to date, having had regard to the site audit findings and the approved provider’s response, I am satisfied the service did not have effective and well-utilised processes to assess, monitor and review staff performance. I have given considerable weight to the clear staff evidence that performance reviews have not occurred in some time and I have not given weight to evidence the nurse practitioner is engaged in staff performance assessment, as there was no evidence provided to demonstrate this. Similarly, no evidence was provided to show other ways in which, or specific instances when, staff performance was reviewed, or performance management processes initiated. As a result, I am satisfied the service is not compliant with Requirement 7(3)(e).

Regarding the remaining Requirements, consumers and representatives said staff engage with them in a kind and caring manner, however some said they felt rushed and disrespected at times. During the site audit, observed interactions between staff and consumers were generally kind and respectful. Interviewed staff had sound understanding of sampled consumer needs and preferences, which aligned with information contained in consumer care plans.

The service demonstrated there are processes in place to ensure recruited staff have relevant qualifications and knowledge to perform their roles. Position descriptions outline expectations; however, it was noted these are not provided to staff upon commencement. The organisation supports the service to verify staff credentials, conduct probity checks of new staff and monitor staff registrations and worker screening expiry dates.

**Standard 8**

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| Organisational governance | | Non-compliant |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

## Findings

The Assessment Team recommended each Requirement is this Standard as not met.

Regarding Requirement 8(3)(a), the Assessment Team found interviewed consumers and representatives were not satisfied with their level of engagement in the development, delivery and evaluation of care and services. Five interviewees expressed concern at the management and running of the services, with four reporting that ‘resident and relative’ meetings had not occurred in some time. Two interviewees expressly reported concerns with the management of the service since the change in ownership and management had occurred. Management reported consumer meetings were planned to resume and be held on a monthly basis and said that feedback forms were used to engage consumers in service development, delivery and evaluation. Although the Assessment Team’s review of meeting minutes showed the last consumer meeting occurred in April 2022, meaningful engagement from the service was not evidenced, the minutes of the meeting had not yet been distributed and no one was assigned responsibility for actioning issues raised at the meeting. The Assessment Team also referred to their previous findings in Standard 6, to demonstrate feedback forms and complaints did not result in meaningful engagement of consumers in the development, delivery or evaluation of care and services. Lastly, management interviews and documentation review demonstrated recent updates to the décor and fittings in the service were carried out without input from consumers.

In their response, the Approved Provider did not agree with all the Assessment Team’s findings but acknowledged areas for improvement in relation to consumer engagement. They noted there are processes and forums in place for consumer engagement but acknowledged they had not been held consistently. The response outlined planned and implemented actions to address the deficits, including resuming resident and relative meetings, with an undertaking service personnel and management will attend. Evidence was provided to demonstrate meetings resumed after the site audit, however meeting minutes provided did not clearly demonstrate consumer input and meaningful consultation about many items discussed. The response contained an undertaking organisation governance documents, policies and procedures will be reviewed to ensure consumers are engaged in all aspects of planning, development, service delivery and evaluation. The response also contained an undertaking to review and update consumer representative surveys and to develop annual or biannual surveys to inform corporate planning.

While I am satisfied the service is undertaking necessary reviews of key policies and procedures to include consumers in the development, design, delivery and evaluation of care and services, the steps taken since audit are minimal and do not demonstrate compliance. The necessary and appropriate actions which are planned to generate change will take time and resources to embed and evidence presented by the Assessment Team clearly demonstrates the service was not compliant with Requirement 8(3)(a) at the time of site audit.

Regarding Requirement 8(3)(b), the Assessment Team recommended not met because of significant deficits in organisational governance. They found minimal evidence to demonstrate the organisation has a governing body which takes concrete steps to satisfy itself the Quality Standards are met, or that it promotes and is accountable for a culture of safe and quality care and services. The Assessment Team found the service has no onsite service manager and the clinical care coordinator performs direct clinical tasks as well as having day-to-day responsibility for the service. One Director of Nursing is responsible for oversight of three services owned by the organisation and they report directly to the owner. Together, the Director of Nursing and owner comprise the governing body, but there is no board in place. The Assessment Team found no evidence governing body members had been trained in the Quality Standards and while there was a clinical governance framework in place, it did not define any roles, responsibilities, accountabilities or relationships between the governing body, executive, clinicians and consumers. The Assessment Team found the governing body does not receive regular reports on all clinical indicators and that feedback and critical incident briefs were not reported to the governing body. Management confirmed the governing body does not formally meet, communication is done informally over the phone. Numerous other deficits were outlined, including (but not limited to) the service’s lack of any internal auditing team to monitor compliance, no history of any internal audit activity, no strategic or organisational planning to improve performance against these Standards and staff testimony they do not receive adequate support from the Director of Nursing who they considered does not spend adequate time on site. Consumers reported never having been introduced to the owner, despite their regular presence on site and the service was not able to provide any example of a change driven by the governing body as a result of consumer feedback, experience or incidents.

In their response, the Approved Provider stated they did not agree with all the findings in the audit report, and also gave a limited acknowledgement of some deficits. They argued they have processes in place to complete internal audits, however did not provide any evidence of any audits carried out at the service. The response outlined a review of clinical reporting processes had been commenced and reiterated the service had engaged external aged care consultants for a three-month period, to support the organisation with review of governance processes. The response outlined numerous planned actions to address the deficits, including on site weekly support and mentoring for the senior leadership team on quality and clinical governance, review and updating of the clinical governance framework to address deficits identified in the site audit and review of the current organisational plan. The continuous improvement plan noted the organisation will implement a committee structure to ensure clinical indicators, feedback, complaints and other pertinent performance measures are reported back to the governing body.

While I acknowledge the Approved Provider has taken some appropriate steps to remedy the deficits in governance identified during the site audit, these do not demonstrate compliance. I have given considerable weight to the lack of formalised governance arrangements and reporting processes. In the absence of sufficient evidence that the governing body promotes a culture of safety, quality or inclusive care or any evidence the governing body has a strategic plan to meet these Quality Standards, I find that the service is not compliant with Requirement 8(3)(b).

Regarding Requirement 8(3)(c), the Assessment Team found deficits in organisational governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints. Regarding information management governance, the Assessment Team relied on evidence concerning the shift from an ECMS to paper-based care management system, which has been previously outlined. Staff interviews confirmed information is missed at handover and finding information about consumer clinical needs is difficult as information is stored in various places. Care staff said, and policy review confirmed, they are not permitted to write progress notes and care staff considered relevant information is not recorded in progress notes as a result. Other changes to the management of information since the change in ownership included removal of a showering schedule, which staff said left them unable to determine which consumers had had their personal care attended to each day. A handover sheet was reviewed by the Assessment Team, who found it had missing and inaccurate information in it.

Regarding governance systems for continuous improvement, the Assessment Team found the service did not identify continuous improvement opportunities and had not used the continuous improvement plan in almost a year. When the plan was in use, there were defects in the information it contained, such that the team concluded it was not a regularly reviewed, ‘live’ document. Management interviews confirmed this to be the case.

Regarding workforce governance, the Assessment Team relied on the evidence and findings previously outlined in Requirements 7(3)(a), 7(3)(d) and 7(3)(e).

Regarding the service’s regulatory compliance governance, the Assessment Team found a lack of understanding of regulatory requirements for chemical and environmental restrictive practices. Sampled care planning documentation for consumers showed some chemically restrained consumers did not have the required assessments and informed consents in place. Care plans also did not show that medications classified as chemical restraints were regularly reviewed by medical officers as required. Consumers were not recognised as being subject to environmental restraint, as previously outlined in Requirement 5(3)(b) and the service did not have a restrictive practice register. Clinical staff did not know if restraints were in place and had not been trained in the minimisation of restrictive practices. The Assessment Team also found the service’s restrictive practices and incident reporting policies did not reflect legislative changes from April 2021. Inconsistent record keeping made it impossible to determine whether serious incidents had been reported to SIRS and the most recent report submitted to the scheme was in 2021. Staff and management had not been trained in SIRS. The Assessment Team also referred to evidence regarding the nominated IPC lead, previously outlined in Requirement 3(3)(g).

In their response, the Approved Provider disagreed with some findings but acknowledged there were areas for improvement, and outlined the measures they have planned, and implemented, to rectify the deficits identified during the Site Audit. These include, but are not limited to, implementing evidence-based standardised care processes and an electronic care management system and incident reporting systems. The service provided an updated restrictive practice register and the continuous improvement plan contained items to ensure consumers have access to keycodes for locked doors and that assessment and other regulatory requirements are met for those who require environmental restraint. The Targeted Education Plan included with the response demonstrated the service has scheduled training sessions on SIRS and the new incident reporting system.

I acknowledge the service has identified appropriate reforms and education needed to address the deficits in governance identified at site audit. However, as these measures are being taken after the site audit, they do not demonstrate compliance and I am satisfied that at the time of site audit, the service had deficient governance systems in place. I find the service was not effectively managing consumer clinical and personal care information or continuously assessing, monitoring and improving the quality and safety of care and services. I am also satisfied the service was not assigning clear responsibilities and accountabilities to staff that were consistent with regulatory requirements and which ensured the service was compliance with regulatory requirements. The service was also not using feedback and complaints to improve results for consumers, because the feedback and complaints process was not effectively implemented or monitored at service or organisational levels. For these reasons, I find the service is non-compliant with Requirement 8(3)(c).

In relation to Requirement 8(3)(d), the Assessment Team found the service did not have effective risk management systems in place relating to the management of high impact, high prevalence risks, dignity of risk and incident management and prevention. To support their recommendation, they relied on evidence previously outlined in Requirements 1(3)(d); 2(3)(a); 3(3)(b), 3(3)(a) and 3(3)(b). The Assessment Team found staff had not been trained or educated on service policies relevant to identifying and responding to abuse and neglect, and they identified that the manual, paper-based incident reporting system was deficient, data it produced was inaccurate and analysis of incident report trends did not occur.

In their response, the Approved Provider did not agree with all the findings but acknowledged areas for improvement. The response outlined measures planned, and being implemented, which have been outlined in earlier Standards. Additionally, the Approved Provider confirmed a review of the organisational incident management system is planned and the purchase of an online incident management system will occur. The response confirmed the service’s engagement of external consultants who will support the service as it reforms the incident management system and outlined training and education of staff in the new system.

I acknowledge the service has identified appropriate reforms and education needed to address the deficits in risk management, incident management and prevention and training for response to abuse and neglect. However, as these measures are being taken after the site audit, they do not demonstrate compliance. I am satisfied that at the time of site audit, the service did not have effective risk management systems in place relating falls, weight loss and pressure injuries and dignity of risk. I find the service’s manual incident reporting system was inconsistently used and ineffective at producing accurate and meaningful data to inform quality improvement efforts and to identify and respond to incident trends and risk. Finally, I am satisfied the service had not supported staff to understand existing policies regarding the identification and response to abuse and neglect of consumers. I am satisfied these systems did not support the service to identify and assess the risks to the health, safety and well-being of consumers and that consequently, the service did not find ways to reduce or minimise clear risks to the consumer cohort. Therefore, I find the service is non-compliant with Requirement 8(3)(d).

Regarding Requirement 8(3)(e), the Assessment Team recommended not met because while there was a documented clinical governance framework in place with policies concerning antimicrobial stewardship and open disclosure, the policies had not been discussed with staff who could not provide examples of their relevance in practice, as previously outlined. A ‘freedom of movement’ policy was reviewed, which mentioned minimisation of restraints but did not provide definitions of all restrictive practices within it. Management interviews confirmed staff had not received training in antimicrobial stewardship, open disclosure or minimising the use of restraint. Use of restrictive practices at the service was not compliant with regulatory requirements, as outlined in Requirements 8(3)(c) and 5(3)(b).

In their response, the Approved Provider disagreed with the not met recommendation and argued that deficits in relation to restrictive practices and open disclosure had already been the subject of assessment in Standards 3 and 6. They response argued that practical application of antimicrobial stewardship principles were evidenced in the site audit report and referred two examples to support their argument.

While I acknowledge the Approved Provider’s response, it does not address the evidence, previously outlined in every Standard of this report, which indicates the lack of a functioning clinical governance framework. I accept some principles of antimicrobial stewardship were described by staff, but this does not overcome the other deficits in restrictive practices knowledge and open disclosure knowledge outlined above. I find there is sufficient evidence to demonstrate the service does not have an integrated and consistent set of leadership behaviours, current policies, procedures or the adequately defined roles, responsibilities and accountabilities which underpin a clinical governance framework. The Assessment Team also brought forth sufficient evidence to show a lack of planning, monitoring and improvement mechanisms implemented at the service, to support safe, quality clinical care. I have had regard to the evidence set out throughout the entire report and the previous non-compliant findings I have reached in 21 Requirements. On this basis, I find the service is non-compliant with Requirement 8(3)(e).

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)